

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-010189

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 378

Primary Registration District No. 4552

Registrar's No. 11

FILED MAR 15 1963

1. PLACE OF DEATH a. COUNTY Wright		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Wright	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mountain Grove		c. CITY OR TOWN Mountain Grove	
Length of stay in 1b Life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 418 High Street		d. STREET ADDRESS (If outside, give location) 418 High Street	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES W. HENSON		4. DATE OF DEATH Month Day Year March 12, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1884
9. AGE (last birthday) 78 Years		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Wright County, Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Francis M. Henson		13b. MOTHER'S MAIDEN NAME Carolyn Perkins	
14. NAME OF HUSBAND OR WIFE Mandy Jane Henson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mandy Jane Henson - Mtn. Grove, Mo	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Influenza</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-10-62 3-5-62	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3-6-63 to 3-12-63 and last saw him alive on 3-12-63 Death occurred at 2:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ed Conner M.D.</u>		22b. ADDRESS <u>1114 Spruce Mo</u>	
22c. DATE SIGNED 3-19-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 3/14/1963		23c. NAME OF CEMETERY OR CREMATORY Green Mountain Cemetery	
23d. LOCATION (City, town, or county) Wright County, Missouri		(State)	
24. FUNERAL DIRECTOR Barber Funeral Home - Mtn. Grove, Mo		25. DATE RECD. BY LOCAL REG. 3-13-63	
26. REGISTRAR'S SIGNATURE <u>Bernice L. Scherman</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No. 361

P. O. Address Mr. Stapp, MD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.